# DOCUMENTATION OF VETERAN CARE (80)

I. PURPOSE: To establish a policy for the accurate and timely documentation of Veteran care information by all disciplines.

II. POLICY: It is the policy of VA Butler Healthcare to provide accurate and timely documentation of Veteran care and activity. The contingency plan will be initiated according to MCM IM-10 Computerized Patient Record System (CPRS). All persons with access to medical records will maintain confidentiality of Veteran information**.**

III. RESPONSIBILITY:

A. The Director, Chief of Staff, and Associate Director for Patient Care Services have the overall responsibility to assure that Veteran care is documented in accordance with established policies, standards of care, and standards of practice.

B. Veterans Health Administration (VHA), by Federal policy, must maintain complete, accurate, timely, clinically-pertinent, and readily-accessible patient records which contain sufficient recorded information to serve as a basis to plan patient care, support diagnoses, warrant treatment, measure outcomes, support education and research, facilitate VHA performance improvement processes and legal requirements.

C. Program managers are responsible for staff compliance with the documentation policy, content, and appropriateness. Each program area will develop its own internal review mechanism for documentation in the medical record consistent with VHA and organizations such as The Joint Commission, The Commission for the Accreditation of Rehabilitation Facilities (CARF), and The College of American Pathologists (CAP).

D. The Medical Records Committee is responsible for advising and recommending improvements regarding the documentation of Veteran care.

E. The Health Informatics Specialists (HIS) are responsible for the training of clinical and non-clinical staff, as well as contracted health care professionals in the use and functionality of the electronic medical record.

F. Supervisors are responsible to assure staff competency in documentation**.**

G. Staff is responsible for documentation that is inclusive of the Veteran's assessment, plan of care, status**,** condition, response to interventions and/or treatment/medications, progress toward goals, education, and evaluation of care provided. Best practice is to document at the time of resident care activity but no later than 48 hours unless otherwise specified in Attachments A, B, C, and D.

H. Any change to the documentation timeframes (Attachments A, B, C, and D) will be approved through the Director via a revision to this Medical Center Memorandum. Any change in the context of CPRS documentation will be approved through the Medical Records Committee

as outlined in MCM IM-21 Medical Record Review Committee.

IV. PROCEDURES:

A. Format: The SOAPIER format is the preferred method to document care. Elements of this format will be utilized according to the established guidelines of this policy. All or part of the SOAPIER acronym may be used.

"S" - Subjective: What the Veteran tells the author. This can be a direct quote.

"O" - Objective: Veteran's clinical signs or factual data gathered by observation of the Veteran.

"A" - Assessment: Conclusion reached by the professional staff about the Veteran's condition.

"P" - Plan of Care: What is planned concerning the treatment of the Veterans problems now or in the future.

"I" - Intervention: What is done to, for, or with the Veteran/significant other to resolve any identified problems/needs.

"E" - Evaluation: Veteran's response to care provided and the outcome of the care.

"R" - Revision: Change to the plan of care as the result of a reassessment.

B. Documentation:

1. Documents will be legible, pertinent, accurate, and include only relevant information.

2. Documentation will be entered at sufficient intervals and in detail necessary to accurately record the Veteran’s clinical progress and medical status by utilizing the CPRS. Specific documentation requirements are outlined in Attachment A, B, C, and D.

3. Approved abbreviations, according to Medical Center Memorandum IM-16 Approved Abbreviations and Symbols for Medical Records will be used when documenting in CPRS.

4. Contingency Plan when CPRS is not available:

a. All manually maintained documentation will be completed on approved medical record forms.

b. Approved forms will contain the date and time the note is written.

c. Errors in manual charting will be crossed out with a single line and the word error written above it with the date and the writer's initials.

d. Errors in manual charting will not be erased or eradicated.

e. Full signature and title will be written immediately following the ending of the

manual document.

f. No blank lines will be left between entries.

g. Late entries will be written on the progress note form with the date and time of the note in real time. The note must be designated as a late entry and the reason for the late entry must be documented. A late entry is considered documentation greater than 48 hours after resident care activity unless timeframes otherwise specify in Attachment A, B, C, and D.

5. An addendum is made in CPRS when a supplemental note is needed to add meaning or explain the previous note. This note is labeled "Addendum".

6. Consults will be completed in CPRS by the point of contact as indicated by Program Line process.

7. Late entries are entered in CPRS with the date and time of the note in real time. The note must be designated as a late entry and the reason for the late entry must be documented. A late entry is considered documentation greater than 48 hours after resident care activity unless timeframes otherwise specify in Attachment A, B, C, and D.

8. Errors in CPRS will be documented according to Medical Center Memorandum IM-10 Computerized Patient Medical Record System (CPRS). Erroneous document entries will be corrected by entering an addendum in CPRS to reflect the indicated document is in error. A VistA e-mail message is sent to G.Erroneous Mailgroup for title change to “erroneous note”.

9. Screening, Assessment, and Re-Assessment:

a. Long Term Care Residents in the Community Living Center will be assessed upon admission and according to the Resident Assessment Instrument/Minimum Data Set (RAI/MDS) requirements. The initial assessment is completed upon admission and includes: current diagnosis, medications, and treatments; physical and neuropsychiatric status, communication status, functional status, rehabilitation potential, nutrition/hydration status, oral health, psychosocial status, spiritual needs, cultural and ethnic factors that may influence care; and the resident’s personal preferences.

b. Veterans in the Hospital Based Home Care (HBPC) Program will be assessed upon admission and annually. The assessment, based on the Veteran’s condition and needs, includes pertinent diagnoses, physical findings and history, functional status, psychosocial status, cultural or religious practices that may affect, care that the family or support system is able to provide, education needs, nutritional status, medication history and current use, and equipment needed in the home.

c. Veterans enrolled in the outpatient behavioral health program will be screened for nutritional status, legal status, and vocational status. Veterans for whom a more in-depth assessment is indicated will be assessed by the clinician or referred for further treatment.

d. Veterans in the Residential Rehabilitation Treatment Program will be assessed upon admission. The assessment, relevant to care, treatment and/or services, will include living situation, leisure and recreational interests, religion or spiritual orientation, cultural preferences, military history, financial issues, language preference, and ability to self care including medication administration.

e. Veterans in the ambulatory care program will be assessed by the provider at each scheduled provider visit and as needed. The assessment, which is based on the condition and needs of the Veteran, includes the physical, psychological, and social status, nutrition, hydration, and functional status.

f. Veterans in all programs will be screened, assessed, and reassessed as indicated in MCM PC-39 General Pain Management Program.

g. Veterans in ambulatory care, home care, and behavioral health will be screened for various health factors. The clinical reminder serves as an alert to notify staff as each screening is due. Positive screenings require a more in-depth assessment by the clinician.

10. Veteran Education:

a. Each program (Long Term Care, Hospital Based Primary Care, Behavioral Health, and Ambulatory Care) will provide education and training based on each Veteran's needs and abilities.

b. The Education Evaluation will determine the education and training needs of the Veteran and will include an evaluation of the Veterans understanding of the education and training provided.

11. Timeframes: Program-specific documentation requirements can be found in Attachments A, B, C, and D.

V. REFERENCES:

The Joint Commission Comprehensive Accreditation Manual for Ambulatory Care, Long Term Care, Behavioral Health and Home Care

Medical Center Memorandum IM-16, Approved Abbreviations and Symbols for Medical Records

Medical Center Memorandum IM-10 Computerized Patient Record System

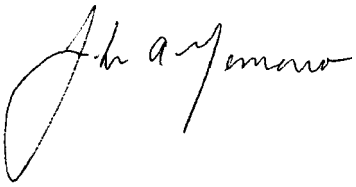
Medical Center Memorandum IM-21 Medical Record Review Committee

Medical Center Memorandum PC-39 General Pain Management Program

Medical Center Memorandum PC-111 Assessment, Prevention and Treatment of Pressure Ulcers

VHA Handbook 1907.01 Health Information Management and Health Records

VI. RESCISSION: Medical Center Memorandum IM-32 dated March 31, 2012.



JOHN A. GENNARO
Director

Attachments: A, B, C, D

DISTRIBUTION: D

(Automatic Review Date: July 02, 2016)

ATTACHMENT A

LONG TERM CARE DOCUMENTATION REQUIREMENTS
(Entered and signed within 48 hours of encounter unless otherwise indicated)

| DISCIPLINE | DOCUMENT | TIMEFRAME |
|---|---|---|
| **Chaplain** | Admission Assessment - LTC | Within 14 days of admission |
| | Reassessment - LTC | Every 90 days |
| | Admission Assessment - Hospice, Palliative Care | Within 24 hours of admission |
| | Reassessment - Hospice, Palliative Care | Every 14 days |
| | Progress Note | With any change in condition/in response to care/treatment |
| | Palliative Care Note (Hospice) | With any change in condition/in response to care/treatment |
| | Bereavement Telephone Note | Within 14 days of death |
| | | |
| **Registered Dietitian** | Admission Assessment | Within 7 days of admission |
| | Progress Note (Level IV) | Monthly |
| | Progress Note (Level I, II, III) | Quarterly |
| | Palliative Care Note (Hospice) | With any change in condition/in response to care/treatment |
| | Plan of Care | By day 21 of admission |
| | | |
| **Nursing** | Admission Assessment | Within 8 hours of admission |
| | Progress Note | Daily for 3 days after admission |
| | Progress Note | With any change in condition/in response to care/treatment |
| | Progress Note (fall) | Each shift for 3 days after fall |
| | Palliative Care Note (Hospice) | With any change in condition/in response to care/treatment |
| | Death Note (Support) | All deaths |
| | Braden Skin Assessment | On admission/weekly |
| | Monthly Note | Monthly on all residents |
| | Plan of Care (interim) | Within 8 hours of admission |
| | Plan of Care (complete) | By day 21 of admission |
| | Education Assessment | Within 8 hours of admission |
| | Pain Assessment | Within 8 hours of admission/when pain is |

| | | |
|---|---|---|
| | | identified |
| | Pain Reassessment | Weekly if pain is a problem |
| | Discharge Summary | On day of discharge |
| **Restorative Nursing** | Assessment | Within 72 hours of admission |
| | Reassessment | Quarterly |
| | Plan of Care | By day 21 of admission |
| | | |
| **Physical Medicine and Rehabilitation Service (PT, KT, OT, ST)** | Functional Assessment/Nursing Admission Safety Assessment | Within 4 hours of admission (Off tour admissions: PCC/Charge RN completes and therapy reviews next business day. |
| | Progress Note - LTC patients | With each visit (in response to care/treatment) |
| | Progress Note - CIIRP Patients | Daily (in response to care/treatment) |
| **Recreation Therapy** | Life History | By day 7 of admission |
| | Recreation Assessment | By day 7 of admission |
| | Plan of care | By day 21 of admission |
| | Progress Notes - LTC Patients | Quarterly |
| | | |
| **Pharmacy** | Initial Assessment | Within 72 hours of admission |
| | Medication Review | Every 30 days |
| | Plan of Care (residents prescribed antipsychotics) | By day 21 |
| | Palliative Care Note (Hospice) | With each visit (in response to care/treatment) |
| | | |
| **Social Work** | Admission Assessment | By day 14 of admission |
| | Reassessment | Annually |
| | Progress Notes | With each visit in response to care/treatment |
| | Education on Advance Directives | Upon admission/annually |
| | Advance Directive | Reviewed quarterly at IDT |
| | Progress Note | Quarterly |
| | Plan of Care | By day 21 of admission |
| | Palliative Care Note (Hospice) | With each visit (in response to care/treatment) |
| | | |
| **Dental** | Oral Health Assessment | By day 14 of admission |
| | | |

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|---|---|---|
| **Medical Provider** | History and Physical – Medication Reconciliation | Within 48 hrs of admission |
| | Progress Note | In response to medical care/treatment |
| | Progress Note | Every 30 days |
| | Palliative Care Note (Hospice) | With any change in condition/in response to care/treatment |
| | Discharge Summary | Within 72 hours of discharge |
| | Death Note (Base) | All deaths |

ATTACHMENT B

AMBULATORY CARE DOCUMENTATION REQUIREMENTS
(Entered and signed within 2 business days of encounter unless otherwise indicated)

| **DISCIPLINE** | **DOCUMENT** | **TIMEFRAME** |
|---|---|---|
| **Health Technicians** | Women's Health Prevention Note | With each visit |
| | Men's Health Prevention Note | With each visit |
| | Clinical Reminders | As due at each visit |
| | Education Evaluation | With initial visit or change in condition |
| | Pain Screening | With each Visit |
| | | |
| **Nursing** | Quick Check Notes | In response to care/treatment |
| | Telephone Glucometer Blood Sugar | In response to care/treatment |
| | Telephone Blood Pressure | In response to care/treatment |
| | | |
| **Medical Provider** | Assessment – Medication List/Reconciliation | With each visit |
| | Progress Note | With each visit |
| | Braden Skin Assessment | With initial visit/annually |
| | Problem List/Summary | By the third visit |
| | Pain Assessment | With each visit (if screening is positive) |
| | Pain Education | With each visit (if screening is positive) |
| | Pressure Ulcer risk, prevention, and treatment education | With initial visit/annually |
| | Clinical Reminder Follow Up Assessment | For any positive clinical reminder |

ATTACHMENT C

OUTPATIENT BEHAVIORAL HEALTH/SOCIAL WORK DOCUMENTATION REQUIREMENTS
(Entered and signed within 2 business days of encounter unless otherwise indicated)

| DISCIPLINE | DOCUMENT | TIMEFRAME |
|---|---|---|
| **All Disciplines** | Treatment Plan | Within 3 sessions |
| | Nutrition Screen | Annually |
| | Progress Notes | With each visit (in response to care/treatment) |
| | | |
| **HUD/VASH PROGRAM** | | |
| **All Disciplines** | Treatment Plan | Within 3 sessions |
| | Progress Notes | Within 5 days of patient encounter |
| | | |
| | | |
| **MHICM RANGE PROGRAM** | | |
| **All Disciplines** | Treatment Plan | Within 5 sessions of admission |
| | Progress Notes | Within 5 days of patient encounter |
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| | | |
| **VETERAN JUSTICE OUTREACH PROGRAM** | | |
| **All Disciplines** | Progress Notes | Within 5 days of patient encounter |

DOMICILIARY DOCUMENTATION REQUIREMENTS
**(**Entered and signed within 48 hours of encounter unless otherwise indicated)

| DISCIPLINE | DOCUMENT | TIMEFRAME |
|---|---|---|
| **Nursing** | Admission Assessment | Within 24 hours of admission |
| | Interim Plan of Care | Within 24 hours of admission |
| **Nurse Practitioner** | History and Physical | Within 72 hours of admission |
| | Discharge Summary | Within 72 hours of discharge |
| **Vocational Rehab Specialist** | Vocational Assessment | Within 5 days of admission |
| **Psychologist** | Psychological Assessment | Within 5 days of admission |
| **Chaplain** | Spiritual Assessment | Within 5 days of admission |
| **Case Managers** | Treatment Plan | Within 5 days of signed first contract |
| | Treatment Plan Updates | Every 30 days after initial treatment plan |
| | Case Management Individual | Weekly during Phase I, every |

| | | |
|---|---|---|
| | Notes | 2 weeks thereafter |
| | | |
| **All Disciplines** | First Contract | Within 5-7 days of admission |
| | Progress Notes | With each visit (in response to care/treatment) |

ATTACHMENT D

HOME BASED PRIMARY CARE (HBPC) DOCUMENTATION REQUIREMENTS
(Entered and signed within 5 business days of encounter unless otherwise indicated)

| DISCIPLINE | DOCUMENT | TIMEFRAME |
|---|---|---|
| **Nursing** | Assessment | On admission and annually |
| | Progress Note | Monthly |
| | Treatment Plan | Quarterly |
| | Medication List | With each visit in response to care/treatment |
| | Clinical Reminder | As due with each visit |
| | Telephone Encounter | In response to care/treatment |
| | Fall Note | If fall is reported at visit |
| | Discharge Addendum | On discharge |
| | | |
| **Physical Therapy** | Functional Status Assessment | On admission and annually |
| | Environmental Assessment | On admission and semi-annually |
| | Progress Note | With each visit in response to care/treatment |
| | Treatment Plan | Quarterly |
| | Fall Note | If fall is reported at visit |
| | Discharge Addendum | On discharge |
| | | |
| **Social Work** | Psychosocial Assessment | On admission and annually |
| | Caregiver Assessment | Annually |
| | Treatment Plan | Quarterly |
| | Progress Note | With each visit in response to care/treatment |
| | Discharge Addendum | On discharge |
| | | |
| **Registered Dietitian** | Assessment | On admission and annually |
| | Treatment Plan | Quarterly |
| | Consult | With each visit in response to care/treatment |
| | Fall Note | If fall is reported at visit |
| | Discharge Addendum | On discharge |
| | | |
| **Pharmacy** | Treatment Plan/Medication Reconciliation | Quarterly |
| | Progress Note | With each visit in response to care/treatment |
| | Fall Note | If fall is reported at visit |
| | Discharge Addendum | On discharge |
| | | |

| | | |
|---|---|---|
| **Certified Registered Nurse Practitioner** | History and Physical | On admission and annually |
| | Narrative Note | In response to care/treatment |
| | Fall Note | If fall is reported at visit |
| | | |
| **Treatment Plan Coordinator** | Admission Evaluation | On admission |
| | Treatment Plan Summary | Quarterly |
| | Discharge Base Note | On discharge |

HOME TELEHEALTH DOCUMENTATION REQUIREMENTS
(Entered and signed within 2 business days of encounter unless otherwise indicated)

| **DISCIPLINE** | **DOCUMENT** | **TIMEFRAME** |
|---|---|---|
| **Nursing** | Continuum of Care | Every six months |
| | Education Note | On admission |
| | Emergency Management Note | Every six months |
| | Evaluation Note | Quarterly and with alerts |
| | Treatment Plan Evaluation | On Admission |
| | Telephone Encounter | With non alert issues |
| | Discharge Note | On discharge |
| | Screening consult | Initial evaluation |

ADULT DAY HEALTH CARE DOCUMENTATION REQUIREMENTS
(Entered and signed with 2 business days of encounter unless otherwise indicated)

| **DISCIPLINE** | **DOCUMENT** | **TIMEFRAME** |
|---|---|---|
| **Nursing** | Admission Assessment | Within 14 days of admission |
| | Interdisciplinary Treatment Note | Within 21 days of admission and quarterly |
| | ADHC note | Daily |
| | Interdisciplinary Meeting note | On discharge |
| | | |
| **Kinesiotherapy** | Interdisciplinary Treatment Note | Within 21 days of admission and quarterly |
| | Progress note | Daily (in response to care/treatment) |
| | Interdisciplinary Meeting note | On discharge |
| | | |